

14577  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14558

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
c. LENGTH OF STAY IN 1b <u>4 months</u>			
4. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Berlin Nursing Home</u>		d. STREET ADDRESS <u>1 MAIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGIA N. CHICK</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. DATE OF DEATH <u>DEC 22 1960</u>	
6. COLOR OR RACE <u>W</u>		7. DATE OF BIRTH <u>Nov 18, 1885</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years lost birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>PROSPECT VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE D. WARRINGER</u>		14. MOTHER'S MAIDEN NAME <u>ELLENORA BRIGHTWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. J. Richard Burbage, Berlin Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Lobar</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio-sclerotic CVD</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 60</u> to <u>Dec 22 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 22 1960</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>H. Townsend Jr.</u>		22b. DATE SIGNED <u>Dec 24, 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis J. Townsend Jr.</u>		22d. ADDRESS <u>Berlin City, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/27/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORT HILL MEMORIAL</u>		23d. LOCATION (City, town, or county) (State) <u>LYNCHBURG VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>		25a. REC'D BY REGISTRAR <u>DEC 27 '60</u>	
ADDRESS <u>Berlin Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Moore</u>	

STATE OF NEW YORK

1883

March 12 1883

Albany, N.Y.

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully, your obedient servant,

Wm. W. Phelps

Secretary of the Board of Regents

State of New York

Enclosed for you are two copies of the report of the Board of Regents.

I am, Sir, very respectfully, your obedient servant,

Wm. W. Phelps

Secretary of the Board of Regents

State of New York

I am, Sir, very respectfully, your obedient servant,

Wm. W. Phelps

Secretary of the Board of Regents

State of New York

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14578

14559

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	c. LENGTH OF STAY IN 1b <u>71 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 BROAD ST.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE C. CROPPER</u>		4. DATE OF DEATH Month Day Year <u>DEC. 23 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUN 25, 1889</u> 9. AGE (In years lost birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>SIDNEY WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HADDER.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N</u> (If yes, give war or dates of service) <u>N</u>		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT Address <u>GEORGE W CROPPER BERLIN MD</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X Acute Myocarditis attack</u> DUE TO (b) <u>Chr. Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chr. Nephritis</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>3me</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10, 1960</u> to <u>Dec 23, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 23, 1960</u> , and that death occurred at <u>10AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas R. Law</u>		22b. DATE SIGNED <u>12-23-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	23d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A Burbage</u>		25a. REC'D BY REGISTRAR <u>DEC 28 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Harris</u>	

CERTIFICATE OF DEPOSIT

1975

THIS CERTIFICATE OF DEPOSIT is made this 1st day of January, 1975, by the Standard and International Banking Corporation, a corporation organized under the laws of the State of New York, for the sum of \$100,000.00 (One Hundred Thousand Dollars) to the order of the Standard and International Banking Corporation, New York, New York.

The sum of \$100,000.00 is deposited with the Standard and International Banking Corporation, New York, New York, and the same is to be held for the use of the Standard and International Banking Corporation, New York, New York, until the maturity date hereof.

The sum of \$100,000.00 is to be paid to the Standard and International Banking Corporation, New York, New York, on the maturity date hereof, and the same is to be held for the use of the Standard and International Banking Corporation, New York, New York, until the maturity date hereof.

The sum of \$100,000.00 is to be paid to the Standard and International Banking Corporation, New York, New York, on the maturity date hereof, and the same is to be held for the use of the Standard and International Banking Corporation, New York, New York, until the maturity date hereof.

The sum of \$100,000.00 is to be paid to the Standard and International Banking Corporation, New York, New York, on the maturity date hereof, and the same is to be held for the use of the Standard and International Banking Corporation, New York, New York, until the maturity date hereof.

The sum of \$100,000.00 is to be paid to the Standard and International Banking Corporation, New York, New York, on the maturity date hereof, and the same is to be held for the use of the Standard and International Banking Corporation, New York, New York, until the maturity date hereof.

The sum of \$100,000.00 is to be paid to the Standard and International Banking Corporation, New York, New York, on the maturity date hereof, and the same is to be held for the use of the Standard and International Banking Corporation, New York, New York, until the maturity date hereof.

The sum of \$100,000.00 is to be paid to the Standard and International Banking Corporation, New York, New York, on the maturity date hereof, and the same is to be held for the use of the Standard and International Banking Corporation, New York, New York, until the maturity date hereof.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, -18

14584

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 5,6 Film G277 12-21-60 et

Reg. Dist. No.

14560

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Md</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Leif</u> Last <u>Ballard</u>		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	11. BIRTHPLACE (State or foreign country) <u>Pocomoke City Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Ballard</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Nelson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>1-11-11-11-11</u>		17. INFORMANT <u>Martha Ballard</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>Fire - accidental</u> Conditions, if any, which gave rise to immediate cause (b) <u>Conflagration of House</u> (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Worc.</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/9/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-11-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - new church, VG-</u>		24a. REC'D BY REGISTRAR <u>DEC 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALL ILLINOIS STATE DEPARTMENT OF HEALTH - DEPARTMENT OF MEDICAL EXAMINERS - CERTIFICATE OF DEATH



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

14579

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND  
CERTIFICATE OF DEATH

14561

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE BOLLE HADDER</u>		4. DATE OF DEATH Month Day Year <u>DEC. 14, 1960 19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 9, 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MINOS WYATT</u>		14. MOTHER'S MAIDEN NAME <u>LAURA WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT Address <u>MR. THEODORE HADDER, BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>4 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/3</u> 19 <u>56</u> to <u>12-13</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> 19 <u>60</u> , and that death occurred on <u>12/14</u> 19 <u>60</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry U. Sully, Jr., M.D.</u>		22b. DATE SIGNED <u>12/14/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry U. Sully, Jr., M.D.</u>		22d. ADDRESS <u>Berlin, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	
ADDRESS <u>Berlin Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

14562

14580

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>KEOGH</u> Last <u>KEOGH</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 30, 1883</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GARAGE OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>SPRINGFIELD, MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MORRIS KEOGH</u>		14. MOTHER'S MAIDEN NAME <u>ELISA CLARKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR</u>		16. SOCIAL SECURITY NO. <u>MRS. HOWARD KEOGH, BERLIN MD. RFD</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>177X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 31</u> , 19 <u>57</u> , to <u>Dec 31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>60</u> , and that death occurred at <u>11:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. S. Thomas</u>		ADDRESS (Street, city or town, state) <u>Berlin Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>N. R. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/4/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CHURCHYARD</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

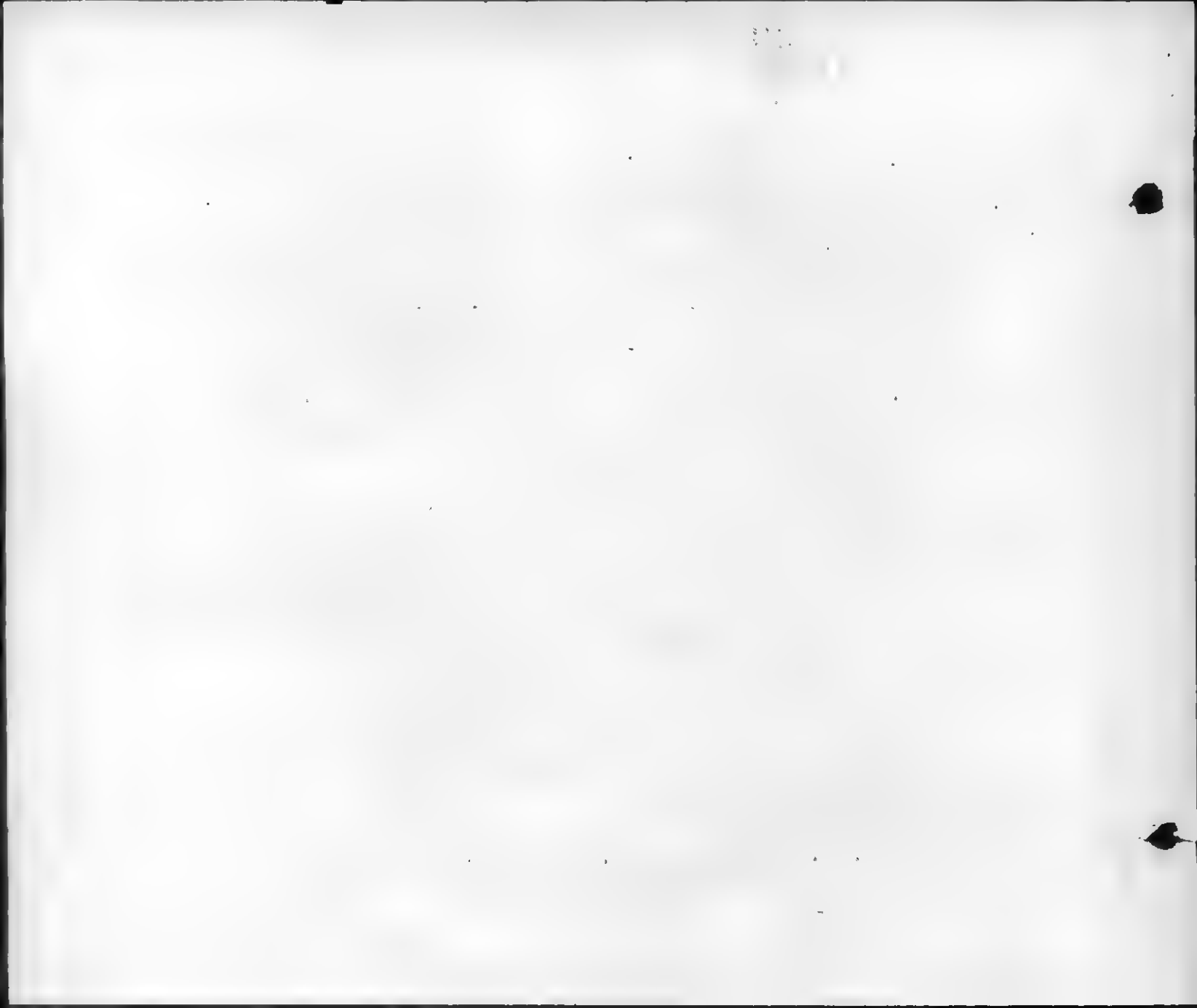
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
14585  
14563  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fourth & Market Streets				d. STREET ADDRESS Fourth & Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE WALTERS KER				4. DATE OF DEATH Month Day Year December 19 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27, 1884		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas B. Walters				14. MOTHER'S MAIDEN NAME Harriett A. Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Miss Bertha Walters, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Pneumonia, hypostatic (c) Cerebral Thromboses DUE TO (b) Cerebral Atherosclerosis, sev. (d) Arteriosclerosis, gen. w. v. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Paralysis, nearly generalized, sec. to b above (2) Cystitis, chronic							INTERVAL BETWEEN ONSET AND DEATH 4 days 12 yrs. 12 yrs. 12 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1948 to 19 Dec. 1960, that (I) (we) last saw the deceased alive on 19 Dec. 1960, and that death occurred at 3 P.M. from the causes and on the date stated above							
22a. SIGNATURE N. E. Sartorius, Jr.				22b. ADDRESS Pocomoke City, Maryland		22c. DATE SIGNED 12-20-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-60		23c. NAME OF CEMETERY Old School Baptist		23d. LOCATION (City, town, or county) (State) Snow Hill, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hennes	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14565

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barber, Harford 1960</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barber (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pr #3</u>		d. STREET ADDRESS <u>1 Pr #3</u>	
3. NAME OF DECEASED (Type or print) <u>Larson</u> First <u>Alexandra</u> Middle <u>Land</u> Last <u>AN</u>		4. DATE DEATH Month <u>12</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1960</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>22</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Working Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>✓</u>	
13. FATHER'S NAME <u>Lewis Moses Jarnell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mary Jarnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>(1)</u>	
17. INFORMANT <u>Elizabeth Mary Jarnell</u> Address <u>1220 E. 1st St. Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(Undetermined) Probably accidental</u> DUE TO <u>Being asphyxiated in bed.</u> Conditions, any, which gave rise to immediate cause (b) <u>Being asphyxiated in bed.</u> (c) <u>Being asphyxiated in bed.</u> DUE TO <u>Being asphyxiated in bed.</u> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius</u> M.D.		DATE SIGNED <u>12/22/60</u>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-24-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fooks Cem</u>	22d. LOCATION (City, town, or county) (State) <u>NE. Berlin, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marston B. Solley</u> ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

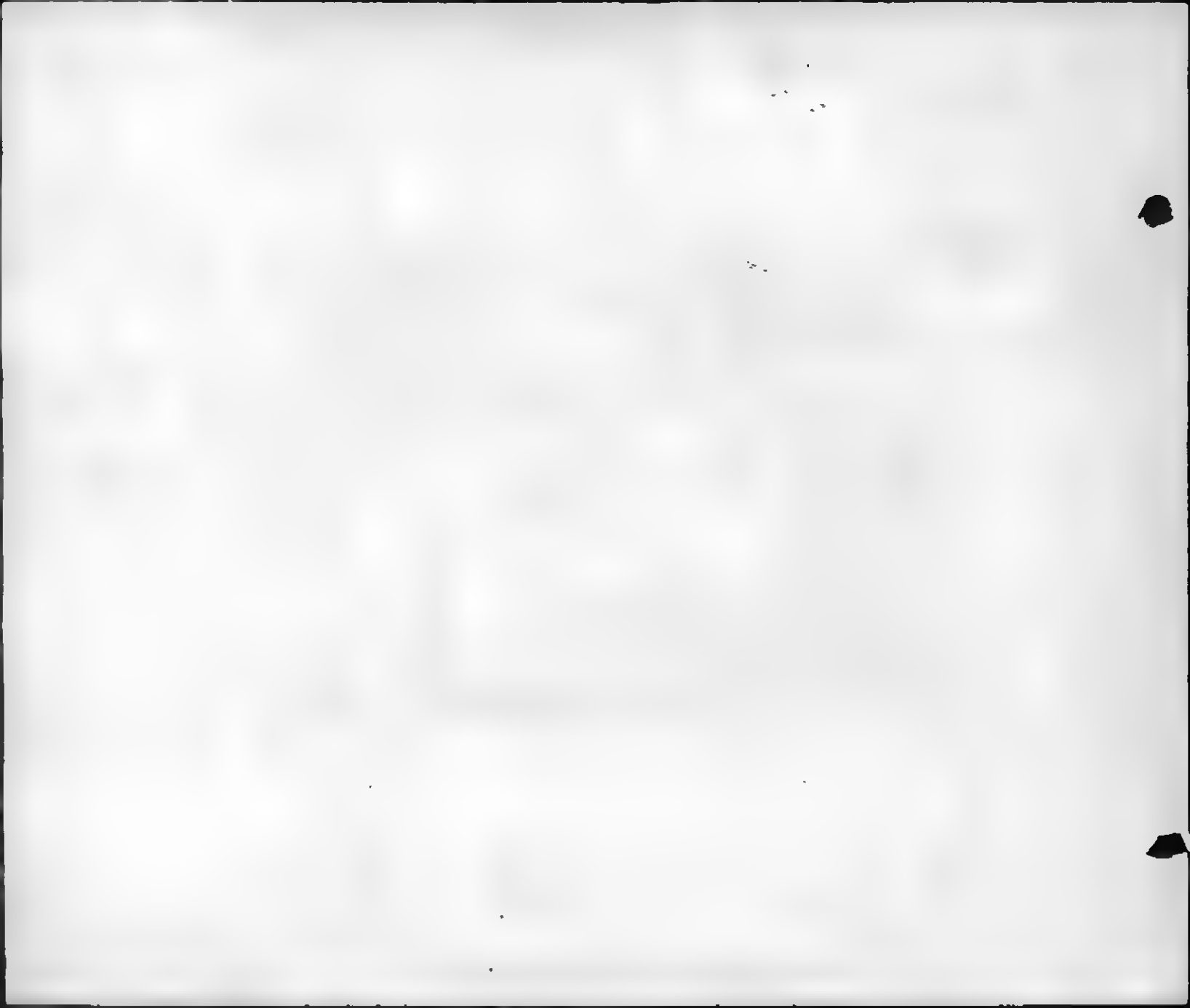
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14565

14589

1. PLACE OF DEATH a. COUNTY <u>Worcester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke (Rural)</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>833 W. 3</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City (Rural)</u>			
f. STREET ADDRESS <u>Rd 2</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Leatherbury</u> Last <u>Leatherbury</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28 1960</u>	9. AGE (in years last birthday) yrs. <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Mins <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>0</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Samuel Leatherbury</u>				14. MOTHER'S MAIDEN NAME <u>Reith Elizabeth Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>0</u>		16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>Reith Elizabeth Jenkins</u> Address <u>Pocomoke</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken neck</u> 761.0 DUE TO <u>Delivery</u> (b) <u>after coming Head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Broken presentation</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr 15</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>while delivering after coming head</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:38</u> p. m. <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pocomoke City</u> <u>Worcester</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>NE Sartorius</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>NE Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wardtown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. White</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>0</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Berlin</u> d. STREET ADDRESS <u>R 2</u>	
3. NAME OF DECEASED (Type or print) <u>MARTIN Neal Lineberry</u> First Middle Last 4. DATE OF DEATH <u>Dec 19 1960</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JAN 31, 1936</u> Month Day Year 9. AGE (In years last birthday) <u>24</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jockey</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HORSE RACING</u> 11. BIRTHPLACE (State or foreign country) <u>GALAX, VA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALBERT LINEBERRY</u> 14. MOTHER'S MAIDEN NAME <u>MAE BOBBITT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>No</u> 17. INFORMANT <u>MR. ALBERT LINEBERRY</u> Address <u>GALAX, VA</u>		18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING, ACCIDENTAL</u> DUE TO <u>WOUND</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DU TO</u> DUE TO (c) <u>EXPOSURE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Stepped into deep water by accident while boating</u> 20c. TIME OF INJURY Month, Day, Year <u>3:05 p.m. Dec 19, 60</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bay at 20th St</u> 20f. (City or town) <u>Ocean City</u> (County) <u>Wor. Md.</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Dec 20, 1960</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>DEC. 23, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>LINEBERRY Cem.</u> 22d. LOCATION (City, town, or country) <u>GALAX, VIRGINIA</u> (State)	
23. FUNERAL DIRECTOR <u>Anna A. Barbage</u> ADDRESS <u>Berlin Md</u> 24a. REC'D BY REGISTRAR <u>DEC 23 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Clara A. Francis</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14586

14567

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived) If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>			c. LENGTH OF STAY IN 1b <b>25 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>402 Market Street</b>				d. STREET ADDRESS <b>402 Market Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Vernon</b> Middle <b>Chestnut</b> Last <b>Miles</b>				<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 27, 1900</b>	
9. AGE (In years last birthday) yrs <b>60</b>		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		11. IF UNDER 24 HRS: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boat Captain</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Freight</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Moody K. Miles Sr.</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW #2 228-32-2745</b>		17. INFORMANT <b>402 Market Street Mrs Edna Miles, Pocomoke City, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, Lung</b> <b>163X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 - 4</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 21, 1959</b> to <b>Dec 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 3, 1960</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles W. Trader</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE, SIGNED <b>12-4-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>				22d. ADDRESS <b>302 Market St., Pocomoke City, Md.</b>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-5-60</b>		23c. NAME OF CEMETERY <b>Bethany Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>C. L. S. Kline</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card properly. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

11

14582

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14568

1 PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHELAN CITY</u>				c LENGTH OF STAY IN TB <u>70 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>STEPHEN JACKSON ZULLIN</u>				4. DATE OF DEATH Month Day Year <u>DEC 5 1960</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 4, 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN ZULLIN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>		17 INFORMANT Address <u>MR. HORACE E. ZULLIN, BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ectymoseles</u> DUE TO (c) PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>1960</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1960</u> and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>12/8/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. R. Thomas</u>				22d. ADDRESS <u>Baltimore, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 12 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14583  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14563

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>			
c. LENGTH OF STAY IN 1b <u>19 yrs</u>				d. STREET ADDRESS <u>400 Sixth Street</u>			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>J.</u> Last <u>Robins</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19 - 1884</u>	
9. AGE (In years, last birthday) <u>76 3/4</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Newark, MD</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Gordon B. Jones</u>				14. MOTHER'S MARRIED NAME <u>Esther Bowen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>M. James B. Robins</u>				Address <u>Ocean City, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Breast</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>6-22-60</u> <u>5 1/2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 18, 1940</u> to <u>Dec 18, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 18, 1960</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>J. Thomas</u>				22b. DATE SIGNED <u>12-18-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. Thomas</u>				22d. ADDRESS <u>Ocean City, MD</u>			
23a. BURIAL, CREMATION, OR DISPOSAL <u>Burial</u>				23b. DATE THEREOF <u>Dec 20/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne L. Harris</u>				25. REGISTRAR'S SIGNATURE <u>Clifford S. Harris</u>			
25a. REC'D BY REG-STRAR <u>DEC 21 '60</u>				25b. REGISTRAR'S SIGNATURE			



TO HOSPITALS AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

14587

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14570

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY (in 1b) <u>28 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>240 Martin St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>E.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24 - 1878</u>	
9. AGE (In years last birthday) <u>83 7/10</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. When if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Simplemerville Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Matthie Pordue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Carlton S. Smith</u>		Address <u>Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Cardiovascular Disease</u> (b) <u>10 days</u> (c) <u>Some years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1958</u> to <u>12-10-60</u> , that (I) (we) last saw the deceased alive on <u>12-10-1960</u> , and that death occurred <u>12-10-60</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.		22b. DATE SIGNED <u>12/10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr.</u>		22d. ADDRESS <u>Berlin, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Taylor Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Simplemerville Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Tammis</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Smith</u>			





14588

## CERTIFICATE OF DEATH

14571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>10 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>E.</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 8, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elias W. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Sarah V. Aydelotte</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Horace M. Jones, Pocomoke City, Maryland</b>		Address <b>R.F.D. 3</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Arteriosclerotic Heart Disease - Diabetes Mellitus</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 15</b> , 19 <b>60</b> , to <b>Dec 23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec 23</b> , 19 <b>60</b> , and that death occurred at <b>8:20 am</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald F. Fletcher, Jr.</b>		ADDRESS (Street, city or town, state) <b>Horsey, Va</b>	
PHYSICIAN'S NAME (Type) <b>Donald F. Fletcher, Jr.</b>		DATE SIGNED <b>12/27/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-60</b>	
22c. NAME OF CEMETERY OR CREMATION <b>Remson Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Rural-Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Denny H. Watson</b>		ADDRESS <b>Pocomoke City, Md</b>	
24a. REC'D BY REGISTRAR <b>DATE DEC 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. S. Knapp</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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